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To: Supervisor Zev Yaroslavsky, Chairman
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From: David E. Janssen
Chief Administrative Officer

BLENDING OF DEPARTMENT OF CHILDREN AND FAMILY SERVICES' PUBLIC HEALTH NURSING FUNCTIONS

On March 6, 2007, on motion of Supervisor Antonovich, your Board instructed the Chief Administrative Officer (CAO), in conjunction with the Directors of Children and Family Services (DCFS) and Public Health (DPH), to report back in 30 days on: 1) working with the State regarding the current requirements of the program and any changes that would improve the Health Care Plan for Children in the Foster Care program; 2) how best to blend funding streams in order to maximize federal and State reimbursement and to minimize net County costs (NCC) for Public Health Nurse (PHN) services to all children, whether in their home or outside their home; 3) how other counties fund and manage their PHN services, thus ensuring seamless service delivery regardless of a child's placement status; 4) whether a centralized point of authority, either DCFS or DPH, would maximize service efficiency; and 5) a means of tracking the impact of PHN services on improved outcomes in safety and permanency, and a reduced reliance on detention.

We have held several meetings with representatives from the CAO, DCFS and DPH; communicated with the State; and researched other counties on how best to provide public health nursing expertise to meet the health care needs of children in both in-home and out-of-home care.

Based on our discussions, we recommend the following: 1) that the public health nursing functions remain bifurcated between DCFS and DPH; 2) DCFS and DPH increase existing joint training sessions for all public health nurses to create a mutual understanding of each Department's desired outcomes, specifically, DCFS outcomes of well-being, safety and permanency for children; 3) DCFS and DPH develop an expanded local MOU to delineate the specific roles, responsibilities and supervision for all PHNs to serve children regardless of their placement status; and 4) DCFS and DPH to continue to work together to develop appropriate protocols and consistent data collection activities to improve outcomes in safety, permanency, and a reduced reliance on detention, as requested by your Board.

Background

The State's Health Care Program for Children in Foster Care (HCPCFC) is a public health nursing program administered by local public health departments' Child Health and Disability Prevention (CHDP) programs to provide public health nursing expertise in meeting the medical, dental, mental and developmental health needs of children and youth in out-of-home placement or foster care. PHNs work with the child's social worker as a team member to ensure that children in foster care receive needed health services. The PHNs provide health care oversight and assist the CSW in the entry and update of the child's medical and health information record known as the Health and Education Passport. PHNs also collaborate with the foster care team in the provision of case conferences for foster parents, health care providers, and child welfare, probation, and juvenile court staff.

Currently, there are two groups of PHNs serving children under DCFS care: 65 PHNs from DPH and 48 PHNs from DCFS. DCFS nurses provide services primarily to children entering DCFS supervision (front-end) by assisting Children's Social Workers (CSW) with emergency response referrals and ensuring a comprehensive medical screening and examination is conducted. On average, DCFS nurses provide consultation/referral services for 10,000 children per month and serve an additional 11,000 children per month who remain in their home of origin or foster home. DCFS nurses also work with CSWs in the Department's Joint Second Response program and may accompany CSWs by going to the home of children under the age of three (3) to provide: 1) early identification and assessment of unmet medical or developmental health care needs; and 2) early intervention to improve problems that may be found.

DPH nurses primarily focus on approximately 21,000 children annually who are already dependents (detained) and under DCFS supervision (back-end). Additionally, they provide coordination of health care and assistance in obtaining services for particular health care needs, by both assessment and consultation for approximately 3,800 children per month. The DPH nurses are also primarily responsible for both the Psychotropic Medication Authorization (PMA) reviews and for the F-Rate program by recertifying Special Increment Rates for foster parents with children with exceptional medical/developmental needs. While DCFS nurses are funded through DCFS, DPH nurses are State-funded and must meet State documentation and practice procedures.

Current Funding and Statutory Requirements

The State Budget Act of 1999 appropriated State General Funds for the purpose of increasing the use of PHNs in meeting the health care needs of children in foster care. The funds are distributed through the local CHDP program as an augmentation to operate the HCPCFC. The legal authority for the HCPCFC is the Welfare and Institutions (W&I) Code, Section 16501.3 (a) through (e). However, the Code limits HCPCFC PHN services to those services for which enhanced federal reimbursement may be claimed under Title XIX of the Social Security Act for services delivered by skilled professional medical personnel. Additionally, federal Medicaid regulations state that enhanced Title XIX federal financial participation (FFP) is only available to a state or local agency that directly administers the Medi-Cal program. By law, the local HCPCFC and CHDP programs must be budgeted under the local health department.

The existing MOU between DCFS and DPH primarily delineates the roles and responsibilities of the PHN, CSW and Probation Officer for the Health Care Program for Children in Foster Care. There are no fiscal reimbursement provisions as DPH fully funds PHN services provided to DCFS with State HCPCFC and federal Medi-Cal revenue. DCFS PHN services are financed by 75 percent federal revenue, 17.5 percent State CWS allocation, and 7.5 percent net County cost (NCC). Any shift in services provided by DPH to assume front-end service workload would result in additional NCC.

San Bernardino and Shasta Counties

Unlike Los Angeles County which has a bifurcated PHN program, Shasta and San Bernardino counties budget and supervise PHNs within their health/public health departments. In each county, PHN services are provided via an MOU which stipulates the specific roles and responsibilities and includes specific budgets for these services.

In both counties, the PHNs are budgeted in the public health department, receive their direction from their respective PHN supervisors, and work closely with the CSWs to provide consultations to social workers regardless of the child's placement status.

Both counties reported success with their PHN program. For example, Shasta County has implemented a collaborative and inclusive approach and has experienced very positive outcomes in their HCPCFC, as well as a decrease in the amount of children in foster care. In discussions with Shasta County officials, this reduction has been primarily attributed to a preventive and proactive approach enacted within the county. Examples of the proactive measures implemented are the establishment of a parent partnering program, whereby former parents assisted by the program partner with current parents and serve as mentors. Other factors identified by Shasta County officials as being responsible for the overall success of the program is the multi-disciplinary approach enacted for home visits made under the program and the co-location of all program-relevant county staff, whether it be children and family services, probation, mental health, or substance abuse staff.

State Finding

We contacted the State regarding the feasibility of developing a blended funding model and time study to allow all PHNs to perform both front-end and back-end services within Los Angeles County. The State responded that while it is possible to blend specific case management functions, enhanced FFP can only be claimed for administrative functions that are performed by PHNs employed by DPH.

Centralized Point of Authority

We reviewed the concept of a centralized point of authority similar to that used in Shasta and San Bernardino counties. There are two ways this could be accomplished, either by centralizing all nurses in DCFS or DPH. Although a centralized point of authority could more clearly delineate the lines of supervision, we do not believe the consolidation of PHNs under either model in Los Angeles County would significantly benefit the delivery of services currently provided to children.

Under the DCFS model, transferring the PHNs to DCFS authority, would provide a unilateral line of supervision and could maximize your Board's desired outcomes of well-being, safety and permanency for children. Currently, DCFS nurses report to the DCFS Medical Director while DPH nurse's report to the DPH Nurse Manager and

Director/Medical Director for CHDP. While both serve children under DCFS care, a centralized point of authority under DCFS could increase continuity and consistency of care because: 1) outcomes would be specific and measurable specifically for DCFS goals for children rather than for DPH goals and documentation and reporting purposes required for funding; 2) all PHNs would work together to maximize the comprehensive and smooth flow of services to children; 3) one Director would be responsible for policy and practice protocols, thereby eliminating conflict and providing services on a team basis, integrated and comprehensive, rather than responsiveness to two separate entities; and 4) direction would come from one source enabling DCFS to prioritize work in order to increase efficiency in providing services to children. The primary and definitive disadvantage to this model is the loss of State and federal funding for the 65 PHNs currently in DPH.

The second model would be to put all nurses in DPH and assign them to DCFS offices to work with the CSWs. It appears that these nurses could be used for both "front-end" and "back-end" assignments. However, a specific monthly time allocation study would be required to determine eligible costs to bill to the HCPCFC. DCFS would then have to seek reimbursement for the percentage of time spent on "front-end" work. The advantage of this model is that nurses could work on cases related to all children, without restriction. The primary disadvantages of this model are: 1) that it would be more difficult for DCFS to assure achievement of DCFS goals for family preservation; and 2) if too much of the workload occurs on the "front-end", the HCPCFC funds would not be maximized and additional NCC could occur.

SEIU Local 721 which represents the PHNs has expressed the DPH nurses' unwillingness to merge with DCFS. According to the PHNs, the primary reason for this is the importance of maintaining the current public health structure. Specifically, in the event of a countywide outbreak or bioterrorist attack, it is crucial to the health and safety of county residents that DPH be able to redirect as many PHNs as possible to critical areas. In addition, the DPH nurses believe that the missions of the two departments related to the children are different and that they would be restricted in their Public Health nursing practice.

Tracking Mechanism

Currently, only DCFS nurses collect data which represents countywide outcomes in safety and permanency, which they use to determine the impact of PHN's on the reduced reliance on detention.

Although DPH nurses also collect significant data, the information they gather is primarily for State funding and other medical reporting requirements. The departments have agreed to collaborate in the development of a combined data collection process which can be used by DCFS management to more effectively determine the impact the PHNs have on safety, permanency and the reduced reliance on detention. This process and reporting mechanism will be included in the new local MOU we are recommending between DCFS and DPH.

Conclusion

Based on our review, we recommend that the public health nursing functions remain bifurcated between DCFS and DPH. In addition, we believe that ongoing coordination and expansion of joint training sessions for all PHNs is key to creating a mutual understanding of each Department's desired outcomes, specifically, DCFS outcomes of well-being, safety and permanency for children. Finally, DCFS and DPH need to continue to work together to develop appropriate protocols and data collection activities to enhance continuity and consistency of care and to improve outcomes in safety, permanency, and a reduced reliance on detention, as requested by your Board. To achieve these objects, DCFS and DPH must develop a new local MOU to delineate the specific roles, responsibilities and supervision for all PHNs to serve all children regardless of their placement status.

Please let me know if you have any questions or need additional information, or you may contact Brian Mahan at (213) 974-1318.

DEJ:SRH:DL
GCP:BM:lbm

c: Executive Officer, Board of Supervisors
Director, Department of Children and Family Services
Director, Department of Public Health